BOSTON UNIVERSITY
SCHOOL OF SOCIAL WORK

THE ROLES OF THE SOCIAL WORKER AND THE PSYCHIATRIST IN THE TREATMENT OF NEUROPSYCHIATRIC PATIENTS IN A VETERANS ADMINISTRATION HOSPITAL

A Study of Ten Cases on the Neuropsychiatric Service of the Veterans Administration Hospital at West Roxbury, Massachusetts

A THESIS

Submitted by

Elba Iris Mora

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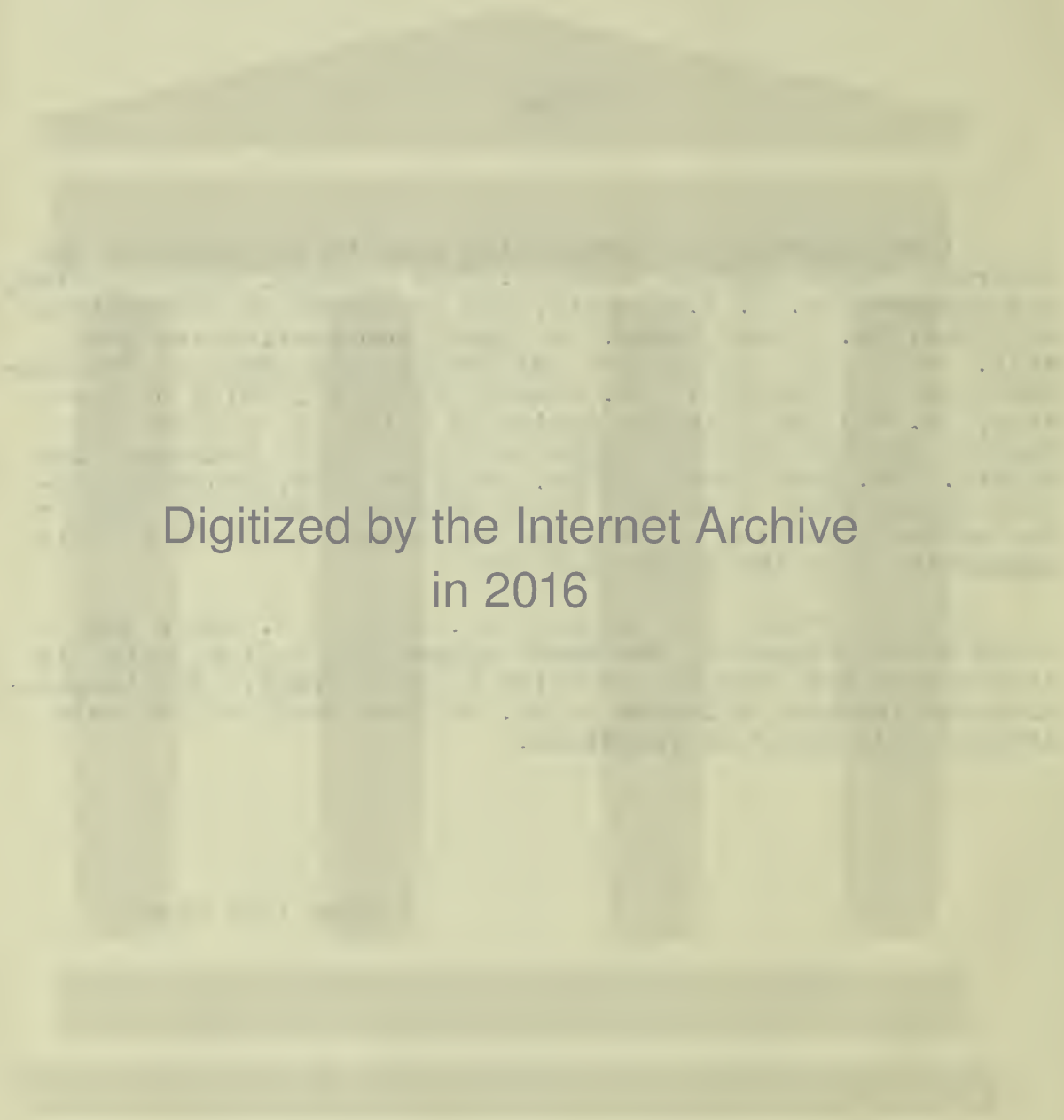
PREFACE

Acknowledgments are gratefully made to the staff of the Veterans Administration Hospital, West Roxbury, Massachusetts, the Manager, Dr. J. T. Bennett, and the Chief of Professional Services, Dr. George Denny, for their cooperation and good will. Particular thanks are due the medical staff of the Neuropsychiatric Service: Dr. Samuel Tartakoff, Chief of Service, Dr. William Clauser, Assistant Chief of Service, and Doctors William Gray and Nicholas Rizzo, Staff Neuropsychiatrists. Dr. John Abbot and Dr. Avery Weisman, Neuropsychiatric Consultants, also gave their interest and their time to the writer's problem of studying the social worker's role in connection with the physician's role.

Special thanks are tendered Mr. Charles L. Rose, the field work instructor, who went "beyond the call of duty" in stimulating the research entailed in this study. The inspiration and teaching afforded by Dr. William Gray and his colleagues will never be forgotten.

Elba Iris Mora



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CHAPTER I

INTRODUCTION

THE TEAM

> The onset of an actual conflict, its nature, the cause of its development, and its outcome; the disappearance of a neurosis, whether it occurs under favorable conditions of life or under influence of a treatment; the treatment itself, its content and cause and its final result; the eventual recurrence of a neurosis after a successful treatment--is at least to a considerable extent determined by the intimate interplay of internal and environmental conditions. In all these problems we are dealing with a dynamic system or sphere of mutual influence consisting of both the dynamic structure of the individual and that of his actual environment. At whatever point in this system change takes place, it influences the rest of it.[1]

Recognition of the fact that the causes of an emotional disturbance are both environmental and internal and that the treatment of the individual must be carried through t aking both areas into consideration has led to the acceptance that the physician, in dealing with an emotionally disturbed individual, can in many instances function better and render more suitable services to the patient if he enriches his contribution with that offered by professionals in related fields. It would be difficult for the physician alone to

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1 Dr. Grete Bibring, "Psychiatry and Social Work", Journal of Social Casework, p. 208.

meet all the treatment needs of the patient. Accordingly, many hospitals have been enriching their program to include a specially trained professional staff who render service to the patient and supplement the physician's activity in the treatment of the patient. These various members of the hospital staff who work together to help the patient achieve maximum potential adjustment may be called a team. In addition to the physician, who is directly responsible for the patient, there may be included consultants, the psychologist, the social worker, the nurse, the vocational rehabilitation expert, the occupational therapist, and the physical therapist. They all integrate their services in a common effort to help the patient.

Collaboration between Psychiatrist and Social Worker

This study will be limited to a consideration of the roles of the psychiatrist and social worker and the collaboration between them. Both the psychiatrist and the social worker are concerned with helping a disturbed individual achieve a better adjustment. Yet they are in two distinct professions differing in training,experience, goals, and approach. The psychiatrist usually attacks the problem of intrapsychic conflicts directly. Dr. Arthur P. Noyes states:

> Psychiatry may be defined as that branch of medicine that deals with the genesis, dynamics, manifestations, and treatment of such disorders and

> undesirable functionings of the personality as disturb either the subjective life of the individual or his relations with other persons.[2]
>
> It is the effort of psychiatry to reconstruct the patient's behavior in the light of the fullest information possible concerning the physical, chemical, physiological, pathological, psychological, educational, and social factors and influences which have been operative in his case.[3]

The social worker in a clinical setting makes his contribution as an integral part of the treatment structure. He helps the patient and/or his family with social problems associated with the illness. The social worker deals with the patient's problems in terms of their expression in or relatedness to reality situations. He may also help the patient to relate to realities in his environment and to look forward to return to the community. The social worker helps the patient to plan for this objective in a realistic way. The patient is helped so that when he later encounters difficulties in his environment, he will cope with them with a better understanding of himself and others concerned.

The social worker may also work with the relatives, helping them overcome some of their fears and anxieties concerning the patient's condition, helping them to accept it and cooperate in plans to achieve a better adjustment of the patient,

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2 Dr. Arthur P. Noyes, Modern Clinical Psychiatry, p.17.

3 Ibid., pp. 2-3.

and helping them to use community resources.

While helping the patient with his problems through these external factors, the worker may achieve a change in the patient's personality, for there is such an intimate interplay between the internal and external forces in the life of an individual. Ruth Garland has stated it thus:

> Because of his continuous support and acceptance of the patient's sick and well self, his non-judgmental understanding attitudes, his knowledge of the attitudes in the way of the patient's social adjustment and his help in getting over these hurdles one by one, the patient may gain increased self-confidence and courage to face the world outside in spite of certain handicaps.[4]

While approaching the patient through the environmental factors, the social worker may establish a positive supportive relationship with him which may be helpful in achieving a reorientation in certain problems of his personality.

Whatever the social worker may do for a patient is always under the management and with joint planning of the physician.

Although psychiatry and social work are two distinct disciplines, they can work together in a complementary manner. Both initially focus on the patient in terms of the presenting symptoms. Later the psychiatrist may also focus on the unconscious factors while the social worker deals with this material as it expresses itself in conscious behavior.

The psychiatrist certainly is interested in the way emotional conflicts are expressed in reality, but the social

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4 Ruth Gartland, "The Psychiatric Social Worker in a Mental Hospital," Mental Hygiene, pp. 289-290.

worker can play a more active role in relating the patient to his social milieu and modifying the environment when this is therapeutically indicated.

Frederika Neuman, in her article "The Preparation of the Case Worker for Psychotherapy" says:

> The skills and the special contribution of both the psychiatrist and the social worker are fused into a joint over-all responsibility. The collaboration between the psychiatrist and the social worker points up the common concern of the two disciplines in the interest of helping disturbed individuals to a better life adjustment. . .Traditionally, the psychiatrist's concern has been with intrinsic personality structure and the social case worker's with the social situation. Since. . .neither is absolute, the fusion of the two specialties in behalf of a disturbed individual becomes clearer and the collaboration of the two specialists logically follows. The integrated psychiatric-social configuration becomes the basis for a unified treatment concept.[5]

Both the psychiatrist and the social worker must be ready to accept the limitations of goals in a particular case. The formulation of treatment plans must be determined more by what is reasonable to try to accomplish rather than by what may be ideally desirable.

The process of collaboration during the treatment of a patient may vary from one setting to another, and this will also determine the effectiveness of the teamwork. The extent to which the psychiatrist and the social worker are inter-dependent varies with the setting. The psychiatric teamwork

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5 Frederika Neuman, in "The Case Worker in Psychotherapy", Jewish Board of Guardians, pp. 30-31.

referred to here is a carefully planned process involving continuous collaboration and contribution of its members based on an objective which becomes more defined and clear as the collaboration proceeds.

The physician, as the leader of the team, is the one who will determine whether the help of the social worker is needed in a particular case or in a particular phase of a case. If the physician determines that the patient needs the services of the social worker, he gives the social worker a general picture of the patient's problem, making specific suggestions as to what he expects Social Service to do for the patient, describing what he expects to achieve with the patient according to his initial impressions. In this referral process, the social worker may contribute by giving his own suggestions which may modify what the psychiatrist had originally in mind as to the social worker's role, and for that matter, the doctor's role, and activity. Progress is discussed in regular conferences, the roles of both possibly changing as the case progresses and in accordance with new problems of the patient which have come to light. These conferences become a prerequisite for the effectiveness of the team as there is a need for the inter-change of findings to achieve the necessary planning for the treatment of the patient.

Factors Influencing the Teamwork

The effectiveness of this collaboration between the psychiatrist and the social worker in helping a patient depends on a number of factors.

The clinical method of pooling knowledge traditionally practiced by the physicians in order to arrive at the wisest medical procedure is a valuable method of integrating all the findings and helping the patient to a better adjustment. Nevertheless, the extent to which the physician may utilize the service of the social worker may vary from one setting to another, depending on the physician's knowledge as to the function of the social worker, the individual ability of the social worker to deal with certain situations, his readiness and training in working with members of another profession, and professional competence of the physician.

Basic in the training of the psychiatrist is an appreciation for the social and environmental factors in the development of emotional problems. This may readily encourage him to seek the services of the social worker.

The nature of the problem presented by the individual patient determines whether the psychiatrist will seek the collaboration of the social worker, as there may be instances when a social worker's contribution may not be indicated, or when the social worker's contribution will be sharply delimited.

The problem presented by the patient also determines the

nature of the respective roles of the psychiatrist and the social worker. In some instances, the social worker may even find himself playing the primary role in the patient's treatment. In other situations, the patient's essential problem is best approached by a psychiatrist.

Purpose of Study

The purpose of this study is (1) to determine how the roles of the psychiatrist and the social worker are set up in given case situations; (2) how the roles are related to each other; (3) the relationship between the nature of the problem and the way the roles are set up; (4) to shed light upon the nature of Psychiatric Social Work with particular reference to its relationship with Psychiatry.

Method of Study

This subject is approached by analysis of case material in accordance with a schedule[6] to study the roles played by the psychiatrist and the social worker in given cases.

A description of the hospital is given with particular reference to the Neuropsychiatric Service and the Social Service department so as to describe the setting where collaboration between the psychiatrist and social worker takes place.

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6 Schedule: For outline of the schedule see Appendix A.

Selection of Cases

The ten cases presented in this study were selected and developed under the supervision of Mr. Charles Rose, Acting Chief Social Worker of the Social Service Department of the Veterans Administration Hospital at West Roxbury, Massachusetts. Statistical sampling was not involved because of the small number of cases. They were drawn from current or near current cases carried by members of the Social Service Department. The cases presented in this study were selected to illustrate how the social worker's role was established and the interrelationship with the psychiatrist's role. Also, a variety of roles and a variety of psychiatric problems were illustrated.

The cases illustrate situations in which cooperation between the social worker and the physician was successfully carried out.

Since the work took place on an acute psychiatric service, the cases tended to be of short duration. The cases extended from one week to two months' duration. All the cases had been closed prior to completion of study.

The ten cases are presented under disguised names.

Sources of Data

After the case was selected, both clinical and social service records were studied and the social worker carrying the case was consulted, after which the case was written up in accordance with a previously prepared schedule. The case

was then analyzed and referred to the social worker and the psychiatrist for additions and corrections. The schedule was prepared with the objective of bringing out the roles of the psychiatrist and the social worker, beginning with referral to Social Service. Also brought out was the process by which the roles to be played were determined.

Other sources of data were the case conference discussions with the casework supervisor and the seminars held weekly with the psychiatrists for the purpose of receiving new referrals and discussing current cases. Since the writer had decided to make a study of the roles of the psychiatrist and the social worker, careful notes were taken on such seminars for this purpose and the specific roles were discussed.

Limitations of the Study

1. Lack of available material for intensive study of the collaboration process in certain cases because the writer was not present at all the discussions with the psychiatrist. This type of material is frequently not placed in its entirety in the record, but lives only in the memory of the social worker who has participated in a given case.
2. The inherent nature of the subject is a difficult one, and it has been sometimes frustrating to try to see clearly what the exact role of the social worker was. The same has sometimes been true in regard to the

role of the psychiatrist.

3. Because the setting was mostly for acute-intensive treatment with quick turnover of patients, it was sometimes difficult to analyze in a complete and leisurely manner what took place.

CHAPTER II

DESCRIPTION OF THE SETTING

The work with patients described in this thesis took place at the Veterans Administration Hospital at West Roxbury, Massachusetts, during 1948 and 1949. The hospital is a 380 bed general medical and surgical institution and was built in 1943. This hospital together with other Veterans Administration hospitals carries out a major responsibility of the Veterans Administration,[1] that of providing medical care "second to none" to veterans.

The medical program of the hospital is organized under three main services, Medical Service,Surgical Service, and Neuropsychiatric Service. In addition there is a Dental Clinic, Pathology Department, Radiological Service, Laboratory Service, and Physical Medicine Rehabilitation Service. Each service is responsible to a Chief of Professional Services,[2] who is in turn responsible to the Manager, a medical man.

Ancillary medical services are Nursing Service, Dietetic Service, Clinical Psychology, and Social Service. Physical Therapy and Occupational Therapy are organized under the Physical Medicine Rehabilitation Service. Another important service which works closely with the physicians is the

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1 See Appendix B

2 Formerly called the Clinical Director

Vocational Rehabilitation and Education Section.

The Neuropsychiatric Service

The Neuropsychiatric Ward is made up of fifty-five beds, thirty of which are occupied by patients with chronic neurological disorders. These patients are in need of permanent care for their chronic and progressive conditions, for which only a hospital type of care would be adequate. The twenty-five remaining beds are occupied by patients with acute neuropsychiatric disorders. This is an open ward so that neuropsychiatric patients who are admitted and subsequently diagnosed as psychotics requiring closed ward care must be immediately transferred to another hospital which has closed ward facilities.

In addition to admissions for treatment there are a number of admissions for neurological or psychiatric observation as requested by the Rating Board.[3]

The acute patients remain in the hospital for an average of two weeks, although some of these patients may remain for a period of several months.

The medical staff of the Neuropsychiatric Service consists of a Chief Neuropsychiatrist, a half-time Assistant Chief Neuropsychiatrist, and two staff Neuropsychiatrists. In

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3 A body which resides in a Veterans Administration Regional office and adjudicates pension claims for both service connected and non-service connected disabilities.

addition two Neuropsychiatric Consultants visit the hospital weekly. A Psychosomatic Unit, at present composed of three Resident Physicians, functions on the Medical Service, but is responsible to the Chief Neuropsychiatrist. The psychiatrists and neurologists attached to the Neuropsychiatric Service also respond to requests for neuropsychiatric consultations from the physicians on the Medical and Surgical Services.

The Social Service Department

Social Service is organized in the Veterans Administration under the Department of Medicine and Surgery. In the hospital, the Social Service Department is immediately responsible to the Chief of Professional Services.

At the time of the writing of this thesis the staff consisted of an Acting Chief Social Worker, two staff social workers, three student social workers and a secretary. Social workers are assigned by wards and are rotated periodically so that they may gain skill in dealing with the entire gamut of illnesses which are treated at the hospital.

The social workers discharge their duties through a teamwork relationship with the physicians and other personnel concerned with the treatment of the patient. Methods utilized in the teamwork are, participation in ward rounds, regularly scheduled conferences with the physicians, and participation in conferences led by the visiting consultants. The social

worker is also a member of a hospital Rehabilitation Board[4] as well as an active participant in the Psychosomatic Conference,which usually meets every two weeks.

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4 This Board which meets regularly on selective cases is made up of the Chief of Physical Medicine Rehabilitation Service as Chairman, Chief of Neuropsychiatric Service, the physician who is immediately responsible for the patient being presented, the Clinical Psychologist, Social Worker, Vocational Advisor, Physical Therapist and Occupational Therapist. The Board mobilizes and coordinates treatment resources for the cases selected which present unusually difficult and challenging rehabilitation problems.

CHAPTER III

PRESENTATION OF CASES

A. Cases in Which the Role of the Social Worker was Mainly in Direct Treatment Problems.

Case I

Mr. John Scott

A. Referral:

1. By Whom:

A staff physician, Neuropsychiatric Service.

2. Reason for Referral:

For help with situational problems which it was felt might ameliorate the patient's condition. It was considered that the patient could be helped in mobilizing the necessary resources to locate his wife who had disappeared and whom the patient wanted to divorce. The patient was also referred for eventual discharge plans.

3. Point at Which the Social Worker Was Drawn in:

At admission to the hospital the patient was extremely tense, tremulous, and depressed. He showed very marked emotional lability, would cry very easily, and during the first few days of his hospital stay was rather seclusive. Due to this, although the physician made verbal referral within a few days of admission, he agreed after consultation with the social worker that no direct contact between the worker and the patient should occur until the physician felt that it was advisable. This actually occurred one week after original referral.

4. Referral Conference

a. Psychiatrist's Contribution and Information from the Records Available:

The physician believed that a factor contributing to the patient's emotional condition was his failure to locate a woman he had married while in the service and who was an "allotment racketeer", that is to say, she contracted a series of marriages without bothering to dissolve the last, in order to collect dependency allotments from each serviceman. This "wife" left the patient shortly after marriage. The patient wanted to secure annulment particularly as he was legally blocked in reference to marrying a current girl friend.

It was believed that the patient was capable of discussing his problems with a social worker and would possibly feel that the worker could give him specific help on something which would have real meaning to him.

From the clinical record the social worker obtained some information concerning family history and background.

The patient had always felt rather out of place and inferior. His mother was a very domineering, neat and clean person who also had similar feelings

of inferiority. The patient's father, on the other hand, was an outgoing, but alcoholic person.

The patient was the third of a family of eight siblings. One of his brothers had a severe anxiety neurosis following the war.

Before going overseas the patient developed a gastric ulcer and was submitted to gastric surgery, being discharged after recovery with 30 per cent disability pension.

Previous to hospitalization the patient had been having a great deal of trouble in relation to an older woman, the one he was blocked from marrying, and he had become increasingly jealous of her. Six months before admission to the hospital he had had an argument with her and had tried to cut his wrists. Three weeks before admission they had another argument and the patient suffered a superficial laceration of the side of the head when she threw a flatiron at him.

The patient was drinking increasing amounts of alcohol.

The psychological tests were indicative of depressive trends with marked rigidity of personality and marked anxiety. There were no findings indicative of psychosis and it was felt that personality

was such that the patient could keep most of his anxiety submerged.

b. Social Worker's Contribution:

The worker had suggested delaying a personal contact with the patient in order to assure effectiveness of social worker's approach.

B. Development of the Referral Process and the Developing Roles of the Psychiatrist and the Social Worker:

This very ill patient showed dramatic response to Social Service activity. The patient was placed in a position of having to analyze how his unfortunate marriage during the service, which he was unable to dissolve, had caused him a great deal of trouble, had contributed to his depression and drinking, and had prevented him from marrying again. He explained his inability to secure an annulment on the basis that he could not furnish the necessary records proving that his wife was already married at the time he had married her.

The social worker sought the advice of the Chief Attorney of the local Veterans Administration regional office. This official was able to furnish specific identification of the wife through a federal district court record where she had been tried for prior violation of the Servicemen's Dependents Act. This would substantiate the patient's libel for annulment. As the Veterans Administration Attorney could not by regulation represent a veteran in court, this matter was

referred to the local legal aid organization.

This tangible help offered by the social worker created a therapeutic worker-patient relationship. The patient saw in the worker a person who wanted and could help him. Thus the social worker found himself in a central position in the patient's psychotherapeutic regime. A sustaining relationship was continued as the steps initiated by the worker to "crack" the legal problem gradually developed.

The problem of a job came up when the patient was sufficiently well, as this was a prerequisite to his being able to function in the community. The social worker's activity helped to prepare the patient for interviews with the vocational advisor in the hospital, who became active in the area of job placement. In this way a new member was added to the team of those working with the patient.

The physician treated the patient in individual psychotherapeutic interviews in the course of which a moderate degree of passive relationship was developed. The main conflict seemed to be one of fear of expressing hostility and aggression because of the consequences of such action, with a resultant tendency toward social isolation. Underneath this, there was evidence of marked feelings of inadequacy and the concept of himself as being something dirty and unwanted.

Through the interviews the physician helped the patient to lessen his anxiety and feelings of depression. The

physician considered this was due to the careful attention the patient's story received without the use of any interpretation or moral judgments. Since the patient felt that people disliked him, the physician had to reassure him constantly of his interest in helping him.

During his course of hospitalization the patient was able to socialize increasingly with other patients and to lose a great deal of his overt anxiety. However, a strong dependency on the hospital developed and there was a difficult problem in disposition. The vocational advisor found a job for him. Although he verbally expressed interest, when he left the hospital to be interviewed by a prospective employer, he took recourse to alcohol and he returned the next day without having accomplished anything as far as getting a job was concerned. Ten days later, he again rather enthusiastically accepted a job suggestion and was discharged to take this job. According to last report he did not report to work. However, he did not reappear at the hospital and as far as is known, has made his own arrangements--probably marginal in nature--in the community.

The physician discussed this patient's case at a consultant conference. The impression was gained of a very severe neurotic condition for which the prognosis was doubtful.

The physician tried to lessen some of the patient's anxiety, which was achieved to a certain extent, but the patient's condition ideally required prolonged hospitalization for which

this hospital was not suitable. The physician as well as the social worker and the vocational advisor were limited in their goals with this patient.

C. Contribution of Case Conference Discussions and Seminars to the Delineation of Roles:

The previously described activity of the social worker was carefully reviewed with the physician before any formulated plans were executed. In this case particularly the social worker could not make any specific plans without the approval of the physician due to the patient's acute emotional problem.

The physician believed that the social worker's role was in dealing with the patient's realistic, tangible problems.

During seminars the physician indicated the limited goals in the treatment of this patient who presented a poor prognosis. His role was to help the patient, not by developing insight into the unconscious causes of his condition, but by acceptance, a non-condemning attitude and by making other treatment resources of the hospital available to him.

D. Relationship between the Nature of the Problem and the Roles of the Psychiatrist and the Social Worker:

The patient's problem was: anxiety state, severe, manifested by symptoms of tension, irritability, hostility and insomnia, accompanied by depressive trends without evidence of psychosis. A disturbing reality problem was his inability

to secure an annulment of his marriage. Accordingly, the physician dealt with the patient's emotional problem and in doing so helped the patient to become more social, more adjusted to his environment. Goals were limited, however, by the nature of the psychiatric condition, and the hospital setting itself.

The social worker dealt with the patient's realistic marital problem, and in doing so established a positive relationship which helped to prepare the patient for vocational advisement and eventual discharge to the community. In the realm of the patient's feelings of inadequacy and rejection, he was helped indirectly by the social worker.

E. Effectiveness of the Social Worker:

In collaboration with the psychiatrist the social worker contributed to avoiding the need for locked ward care for this patient through a supportive relationship and by giving tangible help.

The social worker also paved the way for the patient to utilize the services of the vocational advisor.

F. Summary

The physician referred the patient to Social Service close upon admission for the specific purpose of helping him secure an annulment of his marriage. The physician described the patient as being seclusive, depressed, and inadequate. The plan was to postpone the contact of the social worker with the patient until he would be in a better position to relate. Social

Service contact with the patient took place in fact one week later.

The social worker was able to secure for the patient the help of legal agencies to initiate an annulment of the patient's marriage. This tangible help resulted in a truly therapeutic relationship with the social worker, as the patient saw in the social worker a person who could and wanted to help him. This relationship was sustained until the patient was discharged. The social worker prepared the patient for the services of the vocational advisor, although ultimately the patient did not take any of the jobs offered to him.

In his relationship with the patient the physician was able to see him as an individual in a severe anxiety state manifested by symptoms of tension, irritability, hostility, accompanied by dependency trends and without evidence of psychosis. According to the physician and the neuropsychiatric consultant, prognosis was doubtful. Goals of treatment were limited. The physician limited his activity to helping the patient become less anxious, seclusive, and depressed, through acceptance, reassurance, and a non-condemning attitude. The physician's role was supplemented by that of the social worker. As a result, the patient improved sufficiently to be considered able to function in the community and was accordingly discharged.

CASE II

Mr. Philip Carlson

A. Referral:

1. By Whom:

A staff physician, Neuropsychiatric Service.

2. Reason for Referral:

Original referral was to interview the mother and one of the brothers regarding the patient's behavior at home with particular reference to psychotic symptoms and homosexual behavior.

At the point of referral the physician had very little information as to why the condition had exacerbated, and from the record on previous hospitalization had no information concerning the family's point of view and their observations.

3. Point at Which the Social Worker Was Drawn in:

On the day of the patient's admission to the hospital, the physician referred the relatives for an interview. There had been no social service contact during the first hospitalization four months previous.

4. Referral Conference:

a. Psychiatrist's Contribution and Information Obtained from Records Available:

Previous records were read, and more help concerning the case was obtained directly from

the physician, a few minutes before the relatives were interviewed.

b. Social Worker's Contribution:

Prior to first contact with the case, the social worker suggested that in his contact with the patient's relatives he should focus upon what had happened to this patient during the most recent period subsequent to first hospitalization.

B. Development of the Referral Process and the Developing Roles of the Psychiatrist and the Social Worker:

The original referral was mainly for exploratory purposes. As a result, the physician was helped in establishing a definite diagnosis particularly in regard to the psychosexual problems involved. A picture was obtained of this patient's status in the family and the role of other members of the family in precipitating his psychiatric condition.

The way was paved for new activity by the social worker. The physician requested this time that a relationship be established between the patient and a female social worker so that the patient could experience a non-condemning attitude from a woman. This experience would relieve him of guilt and anxiety customarily involved in his relationships with women. Because the sexual area was so critical in the patient, the social worker was to discourage his production of such material. The physician anticipated that the patient might test the social

worker by producing such material to see if a condemning reaction would come forth. However, the worker should not completely cut off the patient's discussion if he brought it into this area, but allow a limited amount of controlled production without letting the patient feel he was being condemned or rejected.

Another aspect of this new activity was planning for ultimate discharge. As a matter of fact, the worker's initial approach to the patient would be in the guise of an interest in working out such plans. The technical problem was to deal with the patient's anxiety. The physician suggested that if the social worker could not handle it, she should shorten the interview. If the patient showed a desire to talk, the social worker should let him do so. If he should not feel like talking, the patient should not be forced.

The objective problem was that the patient was rejected by his family. Some plans had to be made for discharge, possibly for referral to the Mental Hygiene Clinic.

The role of the psychiatrist was to assume the attitude of a permissive forgiving father figure and through a supportive relationship try to undo the patient's feelings of guilt, anxiety,and fear.

The role of the social worker was originally to establish a positive, non-condemning, supportive relationship with the patient to help him become less anxious while talking to a

"a nice woman". This was achieved gradually, the patient becoming less anxious, his nervous gestures disappearing. While playing this role, the social worker broke down some of the patient's resistances in the initial interviews. A positive transference developed which greatly helped the social worker to help the patient. He developed feelings of affection toward the social worker. Once the positive transference developed, the social worker's activity was to work gradually with the patient's extreme dependency. This was done by stimulating the patient to use a hearing aid, and by getting the patient to think in terms of discharge and a job. The patient was encouraged to use the services of the vocational advisor.

The social worker became as passive as possible in this supportive relationship letting the patient lead the conversation in order to help him understand that he had adequacies in establishing a relationship. The social worker also clarified for him his progress and his few strengths.

Ever since the initial interviews, there was the underlying purpose of preparing the patient for discharge. The social worker took every opportunity to point out to him that he should think in terms of leaving the hospital. The social worker avoided conversation concerning the patient's family, for it was observed that he expressed a great deal of anxiety when his family was mentioned. This area was dealt with by the psychiatrist who had contact with one of the patient's

brothers to try to develop more understanding and acceptance of the patient in his home.

Finally, the social worker had to clarify to the patient the transference that had developed, namely that it was a natural phenomenon in the relationship which had helped him to improve a little and to gain some self-confidence, become less dependent, but it was not the same as an actual life experience in a social setting.

The psychiatrist used his relationship with the patient to help him release some of his anxieties, guilt feelings, and fears while the social worker approached the patient through the environmental factors and everyday conversation such as talking about jobs, reality problems such as hearing trouble, patient's social activities, etc.

C. Contribution of Case Conference Discussions and Seminars to the Delineation of Roles:

Case conference discussions contributed to the social worker's better understanding of her role. They helped to keep the social worker's role distinct from the role of the psychiatrist.

The development of the doctor-patient relationship and the social worker-patient relationship was discussed in weekly seminars. The social worker discussed her activities with the patient in helping him become less dependent, and gave her impressions concerning the patient's attitude toward the

case work relationship and her opinions concerning the need of working gradually with the patient concerning plans of discharge. The physician in turn explained the progress the patient had made. He anticipated that any therapy would be largely in helping the patient adjust better to community life. Complete or perfect recovery was considered unlikely. The social worker also made known to the physician some of the specific techniques used, such as the use of silence to induce the patient to talk and thus prove he was adequate in carrying on a relationship. The physician questioned the advisability of being too sweet to the patient for he might be prevented from showing his aggression. When the social worker felt that the patient was ready for the services of the vocational advisor, she discussed it with the physician, who agreed.

The need of placing a time limit on the interviews was suggested by the physician who considered it necessary in order to prevent extreme dependency and to control transference.

D. Relationship between the Nature of the Problem and the Roles of the Psychiatrist and the Social Worker:

The problem of the anxiety, guilt, and fears of the patient had to be dealt with by the physician. The social worker dealt with the reality problems concerning discharge and his need for establishing a positive relationship with a woman.

While hospitalized, the patient did quite well and showed particular benefit from the relationship with the social worker. The patient was able to express his feelings and to socialize better than before. With this improvement there was a decrease in the amount of overt anxiety. At the time of discharge, he had but occasional attacks of panic-like anxiety which were usually of brief duration and could be worked through by the psychiatrist in a short interview. However, the over-all outlook was not a good one in view of the weakness of ego structure. The dangers that had to be faced could well be estimated by the fact that short periods of constipation produced a temporary regression into the panic state in which the patient was when he went to the hospital.

E. Effectiveness of the Social Worker:

The patient has been out of the hospital for too short a time for one to be able to judge concerning the lasting effectiveness of the social worker's activity. However, the following might be said in support of the contention that the work was effective:

1. From early interviews where mutism predominated, the patient progressed to the point where he verbalized remarkably well. Also in the beginning, he was tense, ill at ease, covered his face with his hands, and did not look straight at the social worker. In later interviews, he was relaxed, and even began to wear his

hearing aid, which made communication much easier.

2. In the initial stages he felt completely inadequate about working. Later, however, he was able to accept vocational guidance. The patient showed a great deal of movement in a genuine interest to go to work, but even at the point of discharge no definite placement was in the offing because of the severe limitations the patient presented as to the kind of work he could accept and the special circumstances of employment which he required.

3. For this patient, who was so close to psychosis and commitment, the physician felt that it was a feat to have retained him on an open ward and finally to be able to discharge him from the hospital to his own home. The physician regarded the relationship therapy of the social worker as having played an important part in saving this patient from further development of mental illness, at least for the time being.

F. Summary

Initially the physician referred the patient's mother and one of his brothers to be interviewed by the social worker regarding the patient's behavior at home with particular reference to psychotic symptoms and homosexual behavior. The referral was made on the day of the patient's second admission to the hospital.

Through the information gathered by the social worker in the interviews with the patient's relatives the physician was helped to establish a diagnosis and to know what the patient's home offered for purposes of eventual discharge.

Later, a new referral was made by the physician for a female social worker to establish a relationship with the patient so that he would experience a non-condemning attitude from a "nice woman". The approach to the patient, as suggested by the physician, was through making plans for eventual discharge. The physician anticipated that goals of treatment would be limited. He made definite suggestions as to the way the social worker should approach the patient and what subjects to avoid in conversation. He described his own role as being that of helping the patient dissipate some of his anxiety and guilt.

There was a close collaboration between the psychiatrist and the social worker, both sharing their activities with the patient and progress observed in him. Since the social worker carried a primary treatment role, this activity was critical, therapeutically speaking. Work with the patient was closely supervised by the casework supervisor and the physician. This supervision kept her role as a social worker clear in her own mind, and prevented her from straying into the role of a psychiatrist.

The effectiveness of the social worker could be measured in terms of the positive changes occurring in the patient,

namely, his becoming expressive in contrast to his initial reticence; his becoming less tense; his taking the initiative in wearing a hearing aid; his interest in using the vocational advisor; his becoming more sure of his role as a man. The social worker's as well as the physician's relationship with the patient avoided the necessity for commitment to a closed ward hospital, and in a relatively short period of time helped make possible the patient's return to the community.

B. Cases in Which the Main Role of the Social Worker was in Dealing with Relatives.

Case III

Mr. Robert MacDonald

A. Referral:

1. By Whom:

A staff physician, Neuropsychiatric Service.

2. Reason for Referral:

The case had been presented by the psychiatrist to the neuropsychiatric consultant who advised that the patient might be helped if his wife could accept psychotherapy for herself. The case was accordingly referred to the social worker.

3. Point at Which the Social Worker Was Drawn in:

The social worker was drawn in within a week of the patient's admission at a joint conference attended by the referring psychiatrist, the social worker, the chief neuropsychiatrist, and the neuropsychiatric consultant.

The patient's problem was in not being able to assume responsibility and in wandering away from the home for months at a time. He claimed partial amnesia for what took place during these episodes. Also involved was alcoholism which the patient minimized. In contrast to the husband's wanderings, the wife developed a phobic reaction which eventually made it

impossible for her to leave the confines of her home.

A definite psychiatric diagnosis had not yet been established at the point of referral to Social Service.

4. Referral Conference:

a. Psychiatrist's Contribution and Information Obtained from Records Available:

The history of the patient was obtained both orally from the physician and from the written entries he had made into the clinical record. The social worker also had the benefit of comments from the neuropsychiatric consultant.

In brief, the patient as a child had been shifted from his home to his grandmother's home and back again and had found his shifting roles in the different family constellations difficult for him to adjust to. Later, the patient was not too successful in professional practice. In the service he did well as an enlisted man, but became delinquent when the responsibilities of officer commission were thrust upon him. Following service, the patient, a married man with two children, depended upon his mother to pay his office rent when she finally withdrew her support. He sold his equipment and abandoned his practice.

b. Social Worker's Contribution:

The social worker suggested a preparatory interview between the social worker and the patient to gain his participation in the plan for his wife's treatment and through him possibly to interest relatives in getting the phobic wife out of the home to attend a first appointment at a psychiatric clinic.

From the history it was evident that the patient's mother in turn had played a rejecting and oversolicitous role. The social worker suggested that the patient's mother be seen. However, it was agreed that this be deferred until activity had been started on the wife's problem.

B. Development of the Referral Process and the Developing Roles of the Psychiatrist and the Social Worker:

The physician suggested to the patient the wife's need for psychotherapy and the possibility that this could be accomplished through the avenues of Social Service. The patient accordingly contacted his wife to come to the hospital for an interview by the Social Service. This was the first time the wife had left the house for eight months. She accepted the suggestion of psychotherapy and the necessary arrangements were made by the social worker for her to receive such treatment in the psychiatric clinic

of a well known local hospital. A few days later, the patient's wife kept her first appointment at the clinic where it was found that she was also in urgent need of gynecological care.

In the course of arranging treatment for the patient's wife, the social worker established a r elationship with the patient himself. After the successful referral of the patient's wife to the psychiatric clinic, the patient was motivated to continue to see the social worker, with the unspoken thought, "You have helped my wife. What about me?" The patient was particularly concerned about the nature of his military discharge. After becoming an officer in the Service, he had gone A.W.O.L. on t wo occasions and was discharged without honor. He had brooded a great deal over the circumstances surrounding his discharge but he had never had enough courage to request a review of his discharge. The patient related that he had been in a neuropsychiatric ward while in the service and he felt he should have been given a medical discharge which would have constituted an honorable discharge. At his request, the patient was referred to a representative of a Veterans Service organization to help him in preparing a petition for review.

While in the hospital the patient also developed a frenzied desire to secure employment. The background of the patient's problem was presented to the vocational advisor.

Meanwhile, with an acute financial problem in the home

of the patient, an emergency request for assistance was made of the local Veterans Assistance Agency in behalf of the patient's family.

When the patient was well on his way to thinking of returning home, and with the wife's phobia having been broken, the role of the patient's mother in his problem became less important. When she was seen by the social worker it was for brief interpretation of her son's condition. She was observed as a woman who was too deeply established in her own behavior patterns for any important change to be made in her attitude toward her son. The focus was seen rather in strengthening the son so that he could assume the responsibilities of a husband and a father.

The physician finally suggested that the social worker arrange treatment at a local psychiatric clinic for the patient since it was not advisable to keep him in the hospital for a prolonged period of time. As the patient had taken the attitude that he needed treatment, he glibly acceded to this idea. Nevertheless, when tested by the social worker as to the date of a first appointment, he became vague. It was left to him to contact the social worker if he decided later on to make an appointment. He failed to do so. This final experience illustrated the modest goals that could be hoped for.

Through individual interviews, the physician dealt primarily with the patient's extreme dependency which made him

feel anxious and tense when he was faced with any responsibility. The physician discussed with the patient some of the problems involved in his conflicts in this area.

The physician considered that his activity with the patient should be minimal due to the long history indicative of dependent personality features. While trying to reduce this dependency, he considered necessary the treatment of the patient's phobic wife in order to make the patient feel more comfortable and easy about his home situation, thus reducing his anxiety in dealing with this difficult situation; helping the patient's mother to become less protective toward her son; helping the patient in plans for obtaining a suitable job; and finally, referring the patient for out-patient psychotherapy so that he could live in the community and assume responsibility for his family. Operating in these four areas was considered vital by the doctor for the purpose of minimizing the patient's dependency. While he worked with the patient directly, he sought the collaboration of Social Service, as already indicated, and also utilized the services of the vocational advisor.

C. Contribution of Case Conference Discussions and Seminars to the Delineation of Roles:

The patient became overactive in seeking interviews with various members of the hospital personnel and it was necessary to have frequent conferences with the physician and the

vocational advisor to keep current and coordinate the activities carried on with the patient. The early impression of the physician and the neuropsychiatric consultant was that hospitalization should be as brief as possible lest the patient develop further symptoms as part of a dependency reaction. However, with some evidence of the patient's improvement, it was considered feasible to have him remain in the hospital a week longer than had been originally planned.

The activity carried out by each member of the team, previously described, was discussed in conferences with the physician, which contributed to the delineation of each one's role.

It was believed that with the lifelong problem involved in this situation, it was not realistic to hope for any sudden or dramatic changes of a lasting nature. Because of the limited nature of what could be done with the patient at the hospital, the physician finally suggested that the social worker arrange out-patient psychotherapy which, as indicated previously, was not carried out.

D. Relationship between the Nature of the Problem and the Roles of the Psychiatrist and the Social Worker:

Because the patient's problem of extreme dependency could be treated only in its acute phases, the activity of the physician, the social worker, and the vocational advisor had to be quick, decisive, and in conformity with the limited goals involved.

The physician dealt directly with the patient's extreme dependency and guided the activity of the social worker, both working in collaboration for the purpose of minimizing the patient's dependency.

The social worker's role was initially to help the patient's wife to accept psychotherapy, and while working with her a relationship was established with the patient.

The social worker referred the patient to the proper resource for a review of his Service discharge.

Since the patient's family had a financial problem, referral was made to a Veterans Assistance Agency.

On the patient's expression of interest in work, the social worker made the referral to the vocational advisor.

The patient began to express resistance to the shortening of his own hospital career. Contact with the mother quickly followed and the mother, to whom the patient meanwhile had appealed regarding his continued need for treatment, was helped to overcome, to a limited degree, her overprotectiveness toward her son.

The limits of hospital treatment in this case induced referral for out-patient psychotherapy in the community. As indicated above, the patient did not accept this plan.

When the patient was discharged from the hospital, his misgivings about himself were still present, but he had been motivated by the physician, the social worker, and the vocational advisor to follow through a course of action involving

regular employment, going home to live with his family, and supporting his dependents.

E. Effectiveness of the Social Worker:

The most effective activity was in terms of the wife's referral to a psychiatric resource. Objectives with the patient himself had to be set low, as already described. If one were to evaluate effectiveness with the patient in terms of limited goals, it would be possible to say that goals were achieved. The fact still remains, however, that when the patient left the hospital, there was no immediate prospect for complete rehabilitation.

F. Summary:

The initial referral to Social Service was at a Consultant Conference one week after admission.

The physician requested that the social worker try to get the patient's phobic wife into psychotherapy.

The social worker suggested personal contact with the patient to gain his participation in this plan for his wife's treatment and also that the patient's mother be interviewed since she appeared to assume an important role in the patient's problem. The physician agreed but suggested that the contact with the mother be delayed until after the wife was seen.

The patient's wife was effectively referred by the social worker to a psychiatric clinic. The patient, motivated by this, sought the help of the social worker for some of his own problems, including a review of his Service discharge,

financial assistance for his family, and securing a job.

The patient's mother was interviewed by the social worker mainly for brief interpretation of the patient's condition.

The physician dealt primarily with the patient's need of dependency which made him feel anxious when he had to assume responsibility.

The patient later became overactive, using all possible resources in the hospital and the physician, the social worker, and the vocational advisor had to work in close collaboration to coordinate activity. It was believed that hospitalization best be brief to avoid further dependency. The physician considered treatment goals in the hospital had best be limited. He requested that the social worker refer the patient for outpatient treatment. This was tried, but without success. The limitation of goals were thus illustrated.

The effectiveness of the social worker was mainly in the referral of the patient's wife for psychotherapy. Some goals were achieved with the patient, but there was not complete rehabilitation.

Case IV

Mr. Robert John Flynn

A. Referral

1. By Whom:

A staff physician, Neuropsychiatric Service.

2. Reason for Referral:

To interview the wife regarding the patient's behavior at home in order to help establish a diagnosis, and to carry on a supportive role with her. Also contact with the wife was to determine the exact nature of the marital status--were they going to be divorced as the patient alleged, or was she "sticking" to him despite his abuse.

3. Point at Which the Social Worker was Drawn in:

The social worker began to play an active role at the time of the wife's first visit to the hospital, which was one week following the patient's admission. The day following the patient's admission, however, the physician brought the case informally to the attention of the worker anticipating that it would be eventually referred.

4. Referral Conference:

a. Psychiatrist's Contribution and Information Obtained from Records Available:

The social worker learned about the case as

soon as the patient was admitted to the hospital from a conversation with the physician who even a t that early date anticipated there would be an eventual referral to Social Service. Following this pre-referral knowledge of the case the physician explained briefly at the point of referral what he wanted from the social worker. At that point the physician brought the patient's wife down from the wards to the Social Service Office. Thus, when the social worker entered into activity with the wife, the clinical record had not been consulted as there was no time, and indeed there was no actual need for it.

b. Social Worker's Contribution:

During the pre-referral period, when it was anticipated that the social worker might be interviewing the wife, there was some discussion between the social worker and the physician as to what part the social worker might play in the situation if the wife were to come in.

At the point of referral the social worker made no verbal suggestion as to his role as there had already been prior discussion of this matter.

B. Development of the Referral Process and the Developing Roles of the Psychiatrist and the Social Worker:

At first the work was considered primarily to be with the patient's wife. Because it was not considered advisable by the physician to have the wife visit further at the hospital, and also because of the patient's paranoid attitude concerning the wife, the social worker did not personally see the wife on subsequent occasions. Later, with the patient's improvement, it was arranged that the patient have personal contact with the social worker in regard to referral to a family agency which would be active with the wife in the area of marital problems.

The physician worked individually with the patient and later, when the patient was ready, he referred him to other treatment resources in the hospital.

C. Contribution of the Case Conference Discussions and Seminars to the Delineation of Roles:

The physician presented this case to the neuropsychiatric consultant for special guidance in organizing a treatment regime in the hospital. The social worker was also requested to present his findings to the neuropsychiatric consultant.

The case was also selected for presentation to the Rehabilitation Board. As stated in the minutes of the Board, the main purpose of presenting this case was to organize the effective handling of the acute phases of therapy. At the Board meeting the work of Social Service was presented as well as the contribution of Physical Therapy, Occupational Therapy,

Clinical Psychology and Vocational Rehabilitation. The psychiatrist, of course, led off the presentation of reports and subsequent discussion with a resume of his own clinical findings.

As a result of these conferences as well as conferences between the psychiatrist and the social worker the roles of the respective participants in the patient's therapy were clearly set up.

D. Relationship between the Nature of the Problem and the Roles of the Psychiatrist and the Social Worker:

The patient came to the hospital with a history of increasingly serious marital discord associated with outbursts of hostility and aggression. He had been increasingly moody, and bothered by an impulse to kill people, particularly those whom he loved. He was paranoid in regard to his wife which took the form of his conviction that she was unfaithful. Despite these dramatic symptoms, he was essentially not a psychotic individual.

The physician limited himself to working with the patient alone. He believed his relationship with the patient would be hurt if he also worked with the wife, as in the transference situation he would have appeared as a rival to the patient.

Through the one interview of the social worker with the wife some light was thrown on how she could, through a changed approach on her part, consolidate the gains achieved

by her husband through the hospital psychotherapy. It was thus apparent to the doctor that the wife needed some kind of help herself. Accordingly the patient was encouraged by the physician to take up personally with the social worker the referral of his wife to a community agency where she could receive this help. The patient accepted this, and the social worker accordingly made the referral of the patient's wife to a family agency.

In initial phases of treatment the patient was not "shared" by the doctor with anybody else. This arrangement was a necessary ingredient in the treatment at that time. In the tapering off process, this dependency had to be broken. The transference was "diluted" by a relationship set up between the patient and the vocational advisor and finally, through the relationship with the social worker on the family agency referral.

The total picture of the patient's treatment cannot be understood in terms of the physician's individual psychotherapy alone. The physician utilized ancillary medical resources within the hospital including Occupational Therapy, Physical Therapy and the Remedial Gymnasium.

At the point of discharge the plan was for the patient to return to see his physician on an out-patient basis, as well as to see the vocational advisor on the job problem.

E. Effectiveness of the Social Worker:

The social worker played an important part in diagnostically ruling out psychosis through interview with the wife. The doctor was also guided by the clarification of the diagnosis to set up a treatment regime by ancillary services. The fact that the wife expressed to the social worker her determination to avoid divorce,if at all possible, made it possible for the physician to orient this patient to the possibility of his returning to his wife.

The wife was confused as to the nature of the husband's illness and was almost in a panic state as to what the possible outcome might be. The social worker was able to give her some reassurance and to help her accept at least the immediate restrictions occasioned by her husband's hospitalization.

The social worker was also effective in referring the patient's wife to a family agency which worked with her in the area of marital problems.

F. Summary

Three days after the patient's admission to the hospital, the physician brought the wife to Social Service. The physician had previously talked to the social worker about this patient and at this time asked the social worker to interview the patient's wife concerning the patient's behavior at home to help establish a diagnosis, to determine the exact nature of the marital status, and to carry on a supportive role with

the wife concerning the need of her husband's hospitalization.

The social worker did not see the wife subsequently, for the doctor recommended her not visiting the hospital because of the patient's paranoid attitude.

The physician initially worked with the patient exclusively. He believed that the doctor-patient relationship would be hurt if he worked with the wife, too, as in the transference situation he would have appeared as a rival.

The physician used other treatment resources in the hospital including Occupational Therapy, Physical Therapy, and Vocational Rehabilitation, which worked together as a team with the physician and Social Service. Rehabilitation Board consideration, conference with the neuropsychiatric consultant, and Social Service conferences served to clarify diagnosis and organize treatment as well as to clarify the role of each member of the hospital staff carrying on treatment activity.

At the point of discharge the plan was for the psychiatrist to continue with the patient on an out-patient basis, for the patient to continue planning for a job with the vocational advisor at the hospital, and for his wife to be seen at a family agency.

The effectiveness of the social worker was in obtaining information for diagnostic purposes, clarifying the marital situation so that the physician could direct his plans accordingly, in clarifying to the patient's wife the reason for her

husband's hospitalization, and in referring her to a family agency.

C. Cases in Which the Role of the Social Worker was in the Area of Economic Hardships Associated with Illness.

Case V

Mr. Louis Angelo

A. Referral

1. By Whom:

A staff physician, Neuropsychiatric Service.

2. Reason for Referral:

The patient was referred because of a financial problem and to secure recent background of the patient's breakdown through an interview with the wife.

It was believed that clarification of the patient's financial status, which played a part in his expressed anxieties, together with related factors in the patient's life would be of help.

3. Point at Which the Social Worker Was Drawn in:

The patient had been in the hospital two days and had been admitted because of feelings of inadequacy and inability to relax, which had endured for about six weeks. This was the first time the patient had sought medical care for his psychiatric condition.

At the point of referral, a psychiatric diagnosis had not yet been established.

4. Referral Conference:

The case was originally referred to the case supervisor. The doctor arranged for the wife to appear at the Social Service office and the supervisor

furnished the physician's referral material to the social worker prior to the social worker's interview with the wife. After the first contact with the wife, the social worker read the formal clinical record and initiated personal discussion with the referring physician.

B. Development of the Referral Process and the Developing Roles of the Psychiatrist and the Social Worker:

The social worker's approach was squarely in terms of the financial problem. The evolution of the work with the wife was as follows:

The wife was concerned about resorting to Public Assistance and the worker's activity in actually making money available to her was of a minimal nature. After the worker accepted her dislike of public charity, the wife was able to express the material which had to do with the familial situation and was related to her husband's illness. For example, the wife could work herself, but she had a six-month old baby. She had been borrowing money from her brother instead of drawing upon an $800 savings account. In order to save rent, they had given up their apartment and had moved in with her parents. She was afraid to tell her husband that she had been borrowing money and would now have to draw upon the savings account to pay back.

When the wife subsequently applied for assistance and was

not granted money immediately because of the bank account, she openly cried to the worker. Through this whole process of being helped with the financial problem, the wife verbalized her own inadequacy, her own need for help, and was even able to verbalize how this ventilation was helping her. Thus, the focus of the interviews shifted to a supportive relationship with the wife on her own emotional problems. It was a short step from this activity to a discussion of her own role in the precipitation of her husband's illness. For example, her solution of working and having the husband take care of the baby upon his discharge was considered in terms of how such a previously tried arrangement had been destructive of her husband's mental health because it took away his feelings of being a man and a breadwinner. (Whenever she was at home, she devoted herself exclusively to the child. In her other unoccupied moments, she took care of sick relatives. Instead of going out with her husband, she gave him money to go alone to the movies or bowling.) During this phase of the worker's activity, the wife became quite self-accusatory, literally blaming herself for her husband's illness. Although there was some betterment of the wife's understanding of her husband's illness, as well as her own role in the illness, the wife's dominating tendencies were apparently too fixed for her mode of behavior in this respect to be changed.

With the relationship set up with the wife, it was easy

for her to present her observations concerning the development of the husband's symptoms during the several months prior to hospitalization. For example, she described his transition from a happy-go-lucky individual to a quiet, introspective, seclusive person who exhibited crying spells and a distressing ambivalence as to whether he should keep his job or take what seemed to be a better one.

In reference to the patient's condition while in the hospital, the wife turned to the social worker rather than to the doctor for information on this score. This arrangement was worked out with the physician in view of the social worker's relationship with the wife and the patient-doctor relationship.

A further subject of discussion with the wife was the patient's behavior while he was at home on week-end passes.

It is noteworthy that while all these activities were going on, the focus on the financial problem was preserved. Thus, when financial assistance by a public agency was finally granted, this event gave further concrete and constructive meaning to the worker's activity.

As the patient's discharge approached, the wife expressed her fears over her husband's being discharged prematurely. The wife's fears had been augmented by the husband's fears on this matter which he had expressed to her. The wife was able to convey to her husband the results of her discussions with the social worker. This supplemented the doctor's discussions with the patient on these points, and served as content of

constructive interaction between husband and wife.

One final activity of the social workerwas in direct contact with the patient which was occasioned by his signing a form necessary to release information to a public assistance agency. The patient at this time brought up concern over not being able to be the breadwinner and fear of premature discharge, which were met by support and reassurance on the part of the worker.

The psychiatrist explored the history of the patient's depressions which appeared related to a psychotic brother, military service, and marriage. Because of the patient's overwhelming concern with his need to return to work, the doctor was handicapped in his effort to get the patient to talk about himself. The physician personally interviewed a brother of the patient who made adverse reference to the patient's wife.

In addition to utilizing the social worker, the physician made use of other treatment resources within the hospital, including Occupational Therapy and the Remedial Gymnasium.

It was believed that prolonged hospitalization was not indicated. The patient was in need of shock therapy, a treatment which was not available at the hospital. The patient was believed capable of undergoing this treatment on an out-patient basis while living at home.

C. Contribution of Case Conference Discussions and Seminars to the Delineation of Roles:

The therapeutic role of the social worker proceeded from

the financial problems in the family. Through this avenue the patient's wife was actually helped to cope with her own emotional problems and the problems associated with her relationship with a mentally ill husband.

In seminars with the physician, the realistic economic problems were described. The physician agreed that these were important and signed a medical certificate attesting to the fact that the patient would be unable to work for ninety days or more. Such a certificate would assure the patient's medical eligibility for public assistance.

The physician presented his role as being limited because the patient required prolonged treatment for which the hospital was not the proper setting.

The social worker presented her findings on the wife which were in accord with the material that the physician had received from the patient's brother. In conference with the physician, the desirability of changing the wife's mode of behavior in reference to her husband, was also set forth.

D. Relationship between the Nature of the Problem and the Roles of the Psychiatrist and the Social Worker:

The patient presented a picture of a very depressed individual. The physician's role was initially to explore the patient's physical and mental condition. He saw the patient in individual psychotherapeutic interviews. He also had an interview with the wife concerning the patient's condition and another with a brother of the patient to determine the

immediate factors in his breakdown. This contributed to an understanding of the wife's attitude toward the patient. The physician considered this necessary for the patient was not very communicative. To help the patient to achieve some improvement, particularly in socialization, the physician utilized Occupational Therapy and the Remedial Gymnasium. These proved to be very effective. Yet the physician felt that the patient needed shock therapy and referral for such treatment on an outpatient basis was made by the social worker.

The presenting financial problem brought the social worker in on the clear-cut role of alleviating this source of the patient's psychiatric condition.

Secondly, the wife's role in contributing to the patient's condition was dealt with by the social worker.

Because of his relationship with the patient it was helpful to the physician to have somebody other than himself work with the wife. It was difficult enough for the physician to establish rapport with the patient as it was, and his entering into a relationship with the wife might have made the doctor-patient relationship even more difficult.

E. Effectiveness of the Social Worker:

Financial assistance was effectively secured despite the manifold difficulties which stood in the way. The patient was successfully discharged home to the care of the wife, who was now in a somewhat better position to cope with her husband's

mental illness. On the other hand, the social worker was not too effective in substantially changing the wife's mode of behavior.

F. Summary

The physician referred the patient's wife to Social Service two days after the patient's hospitalization. The social worker was to study recent background of the patient's breakdown and to help the patient's family in the financial problem which was a part of the patient's anxiety. In making the referral the physician gave a brief account of the patient's condition.

The social worker approached the patient's wife squarely in terms of the financial problem. The wife initially expressed her concern about accepting public assistance, but eventually saw that this was inevitable. She made an application, but was unsuccessful in her first attempt. She was given support and understanding which induced her to try again, and this time was successful.

The relationship established with the patient's wife helped her verbalize her own feelings of inadequacy and how she had been helped by the social worker. Thus, the interviews shifted to a supportive relationship based on the wife's emotional problems. It was a short step to the wife's expression of her own role in the precipitation of the husband's illness. Although she gained some insight in her own role in the matter, her modes of behavior were too fixed for the social

worker to help her in changing completely.

The wife was able to report her own observations of her husband's illness.

Because of the relationship established with the social worker, the patient's wife turned to the social worker for information concerning her husband's progress in the hospital.

The behavior of the patient at home while on pass was discussed, which confirmed the fact that he was making gradual improvement.

All activity with the patient's wife was carried out while focusing on the financial problems.

The physician utilized ancillary services in the hospital in working with the patient. His treatment was mainly to prevent the development of a psychosis requiring locked ward treatment.

The social worker shared her findings with the physician, for example, that the wife was an overactive, dominating person, the reality nature of the economic problem, and the behavior of the patient while at home on passes. The physician in turn advised on the wife's securing financial assistance, for the patient would not be able to work for a long period of time, and the need of clarifying to the wife her dominating attitude toward her husband and helping her change her mode of behavior.

The effectiveness of the social worker was mainly in

helping the patient's wife to secure economic assistance, and in carrying out a supportive relationship with her, letting her express her feelings, which helped her to understand her contribution to the patient's condition. The social worker did not expect complete change in the wife as her patterns were too fixed.

The physician's final request was to refer the patient for shock therapy at a local hospital on an out-patient basis.

Case VI

Mr. Paul Thompson

A. Referral:

1. By Whom:

A staff physician, Neuropsychiatric Service.

2. Reason for Referral:

Physician referred the patient to the social worker to determine what resources could be made available to meet the financial difficulties.

3. Point at Which the Social Worker Was Drawn in:

The patient had been admitted at the hospital for the first time on complaints of fainting and dizzy spells. He had been in the hospital only two days when he brought up his financial problem to the doctor who directed him to go to Social Service.

Diagnosis had not yet been established.

4. Referral Conference:

a. Psychiatrist's Contribution and Information Obtained from Records Available:

Initially no orientation was given by the physician. The patient himself presented his problem to the social worker.

The clinical record consisted mostly of the patient's description of his symptoms.

b. Social Worker's Contribution:

The social worker did not make any suggestions originally since no conference was held with the physician previous to the interview with the patient.

B. Development of the Referral Process and Developing Roles of the Psychiatrist and the Social Worker.

The social worker worked primarily in the area of financial problems. The patient reached out to the social worker of his own accord for he had a real need for help. Nevertheless, in the initial interview the patient seemed to be blocked and to fear rejection. He showed a great deal of uneasiness.

Initially the role of the social worker was to study the financial difficulty and the resources within the patient and his family. The worker gave reassurance to the patient that she could understand his need for assistance, his feeling of uneasiness over having to apply for assistance, and in general had to treat the patient with a non-condemning attitude.

Before coming to the hospital the patient had to give up his job as a night watchman. Because of economic insecurity, he could not afford an apartment and he and his wife were living with a sister-in-law who in turn had a limited income from her husband.

The patient had applied for a veteran's pension, as well as a Federal Civil Service retirement pension, and he wished

his wife to be helped financially meanwhile. She could not work due to an abscess in a hip, and possibly would need hospitalization. If she felt better later on, she would work. She also suffered from "migraine headaches".

The patient showed great concern about his feeling that the social worker would think he was telling a "sad story". As indicated previously, there was a need of the worker being reassuring, time and again, that she understood the patient's need and offered her cooperation. She referred the patient to an assistance agency, although it was doubtful that the patient was eligible since he did not fulfill settlement requirements. Nevertheless, the patient was eager to try this resource. When the public agency aid was not forthcoming, the patient had his wife go to a private veterans' fund where she received a small stipend.

While accepting private aid, the patient identified with his wife's feeling of humiliation and stressed how much he cared for her.

It was considered desirable to let the patient's wife find and use this private resource so as not to feed any dependency in the patient or his wife.

The social worker also supported the wife when she related her "humiliation" over accepting aid. The wife spoke of her own poor health, but subordinated it to her concern over her husband's health.

The social worker's activity was concerned mostly with helping the patient and his wife in accepting community resources. Because the patient's wife showed strength in making the necessary contacts herself, the social worker played a minimal role in this respect.

The social worker's role became primarily a supportive one.

The role of the physician was mostly in the diagnostic area. Upon investigation the following final diagnosis was made: "Latent Asymptomatic Syphilis", "Meniers Disease", Cardiac Neurosis". Some treatment was given for his physical condition.

The worker also played a role in meeting the patient's hostility when he learned that he had no organic heart disease. With the previous positive relationship established, it was possible for the worker to affirm to the patient that he had received careful medical evaluation and on a realistic basis it was necessary for the patient to accept the doctor's findings.

The same problem had to be dealt with in reference to the wife.

C. Contribution of Case Conference Discussions and Seminars to the Delineation of Roles:

The main contribution of conferences with the physician was the clarification of the complex diagnostic picture as it progressively developed. With the patient previously oriented

to being pensioned on total and permanent disability, the contrary picture offered by medical diagnosis was very important. It was established in the seminars that it was necessary to work with the patient in terms of the medical facts.

During the seminars the reality of the patient's financial problem was established. The way the patient handled this problem both in terms of the history and the current casework by the social worker helped establish him in the eyes of the physician as a fairly adequate and well organized individual.

It was believed that the patient would be incapable of accepting completely and immediately a reorientation of his medical picture.

Meanwhile he was to be discharged from the hospital with the recommendation that he go to work. It was believed that the patient, out of dire economic necessity and responsibility to his wife, would seek employment, particularly as he could no longer count on a veteran's pension for the time being, nor a Civil Service disability pension for which he was also hoping.

D. Relationship between the Nature of the Problem and the Roles of the Psychiatrist and the Social Worker:

As indicated previously, this patient was admitted on complaints of constant headaches, hearing trouble in the left ear, heart trouble, dizzy spells and fainting. The physician

initially studied the origin and nature of the symptoms and at the same time made a study of the patient's background. After a thorough physical examination it was found that the patient suffered from "Latent Asymptomatic Syphilis", "Meniers Disease" and "Cardiac Neurosis". Some medical treatment was given accordingly. The patient did not present any serious emotional disturbance except his concern about having heart trouble. This he had been told he had eight years ago and thus he could not accept immediately the doctor's statement that there was nothing wrong with his heart. The physician helped the patient to accept this reality, but it was not totally accomplished, for the heart trouble had brought some secondary gains to this patient. Also, his not being totally disabled would impede his receiving a pension. The physician discharged the patient after he was partially treated for his condition and had received maximum hospital benefits.

The somewhat unanticipated final diagnosis had a marked effect upon the ultimate role which had to be played by the social worker. Originally, with the patient having to plan on unemployability, the primary problem was to plan on temporary financial assistance pending receipt of the permanent veteran's pension. Later the problem became that of having the patient accept his employability. The uniform approach throughout, however, was that of an accepting, supportive relationship, which involved first the patient expressing his

hostility regarding assistance agencies to the worker, and later the worker handling his hostility in regard to the medical diagnosis.

E. Effectiveness of the Social Worker:

As there was no follow-up period available, long term effectiveness of the casework done cannot be determined. However, certain short term objectives were realized. The patient and his wife were helped to help themselves in the matter of the alleviation of the acute financial problem. They were also helped to accept, partially at least, the medical picture which had severely jolted the patient out of a concept of partial invalidism which had existed over a period of at least eight years.

F. Summary

The physician referred the patient to Social Service two days after admission when the patient brought up his financial difficulties to the physician. The social worker's role was to be in the area of the economic problem.

The patient expressed his concern about asking for assistance while discussing his financial problem with the social worker. Due to his illness he was unable to work for a period prior to this hospitalization and he and his wife needed assistance temporarily until his application for a veteran's disability pension could be adjudicated. The social worker oriented the patient as to the resources he could utilize. At the same

time the patient and his wife were given reassurance and understanding regarding their feeling of humiliation over applying for assistance. Thus the social worker's role was predominately supportive rather than that of direct environmental manipulation.

The role of the physician was mostly in the diagnostic areas. The patient presented no serious emotional disturbance. Final diagnoses were "Asymptomatic Syphilis", Meniers Disease", and "Cardiac Neurosis". The patient received medical treatment and the physician also had to help the patient accept the fact that he had no organic heart condition. This the patient found difficult to accept inasmuch as he had been told by a physician eight years before that he had "Myocarditis".

The final role of the social worker was to meet the patient's hostility when he learned that he had no organic heart disease and to help the patient accept his employability, for he would possibly not receive a pension.

The effectiveness of the social worker was mainly in helping the patient and his wife to secure resources themselves for the alleviation of the financial problem and to accept, at least partially, the medical picture.

Case VII

Mr. Peter Moore

A. Referral:

1. By Whom:

A staff physician, Neuropsychiatric Service.

2. Reason for Referral:

Originally the patient was referred for the social worker to refer the patient for treatment at the Mental Hygiene Clinic.

3. Point at Which the Social Worker Was Drawn in:

The patient, thirty-six years old, white, married, had been admitted one week before because of restlessness, irritability, and nervousness of two days' duration. The physician was still in process of studying the patient but anticipated that upon discharge, outpatient psychotherapy would be indicated.

4. Referral Conference:

a. Psychiatrist's Contribution and Information Obtained from Records Available:

The only orientation received from the physician was that he wanted the patient to be referred to the Mental Hygiene Clinic. From the clinical records available it was found that the patient had attacks of nervousness which first appeared while he was in the Service in the form

of gastro-intestinal symptoms and crying episodes. He had been able to work until the admission to the hospital.

There had been severe marital problems due mostly to economic hardship and infidelity. The patient was complaining of nasal obstruction, poor appetite, insomnia, nervousness.

b. Social Worker's Contribution:

The social worker made no suggestions.

B. Development of the Referral Process and the Developing Roles of the Psychiatrist and the Social Worker:

The initial referral in this case changed when the patient came on his own initiative to apply for the services of the social worker concerning financial difficulties in which his family was involved due to his illness. This occurred before the worker had a chance to contact the patient in regard to the Mental Hygiene Clinic referral. The patient had to stay in the hospital possibly for two or three weeks longer than had originally been expected to undergo a nasal operation for polypi. Therefore, the family would need some economic help. The role of the social worker was then to ease his mind concerning the financial difficulty by contacting the necessary agency and verifying for the patient that his family would be helped financially.

At the beginning, the patient was rather demanding and

he tried to stipulate that either he be helped by Social Service or he would use politics. The social worker assumed a supportive role while listening to his troubles.

After the patient's family received financial assistance, he expressed the feeling that he was glad he had used Social Service as he felt it did more than he could have achieved by politics. The patient showed signs of becoming too demanding and the social worker tried to control this dependency by reducing her activity. For instance, in securing medical services for the children, the social worker only suggested possible resources, instead of making the necessary contacts for him.

Finally, the social worker arranged an appointment for the patient at the Mental Hygiene Clinic.

A "bilateral nasal polypectomy" was performed on the patient. According to the psychiatrist, this surgery had some therapeutic effect on his emotional condition because the patient believed that something tangible had been done for him and some physical discomfort had been alleviated.

The physician believed that psychotherapy was feasible in the community, and in the hospital the best therapy for the patient would be a somatic approach in removing the nasal obstruction.

C. Contribution of the Case Conference Discussions and Seminars to the Delineation of Roles:

The conferences and seminars included discussions on the handling by the social worker of the dependency trends in the patient in the area of environmental needs. Dependency should not be fostered in this patient. It would not be helpful to make charity too attractive to him. The social worker believed that there was realistic financial distress as the patient's only income was a small pension and he had five children to support. Still it was important, because of the particular nature of the psychiatric problem, to give help in such a way that dependency would not be increased.

The psychiatrist indicated his impressions drawn from the interviews with the patient. He dealt with the patient's anxiety due to difficulties with his wife. Their disagreement was mainly on the advisability of letting the older girl expose herself to sexual activities with boys. Since the patient improved after the operation and could return to work, the psychiatrist preferred out-patient psychotherapy which would make possible treatment while he worked and supported his large family.

D. Relationship between the Nature of the Problem and the Roles of the Psychiatrist and the Social Worker:

The emotional problem including marital difficulties and an authoritative wife were dealt with by the psychiatrist.

He assumed a supportive role, but without giving in to all the demands of the patient. While on the surgical ward the patient was dealt with by the surgeon on that ward strictly as a surgical problem.

Hospitalization created a financial problem since the patient's job income was lost during this period. The social worker gave direct help within the restrictions imposed by the danger of developing dependency. The social worker did not establish a relationship with the wife, as it was believed best to focus on treatment in the community.

E. Effectiveness of the Social Worker:

Despite the worker's limiting of the patient's aggressive dependencies, a positive relationship was established through which satisfactory arrangements were made for economic assistance for the family during the hospitalization of the patient and follow-up psychotherapy on an out-patient basis was arranged. The social worker also supported the patient in his pride for his children, the good he was getting from the surgical treatment, and his returning home. In a post-discharge contact, the patient confirmed his readiness to keep a first appointment at the Mental Hygiene Clinic. He affirmed that he was feeling better than he had felt for a long time,and informed the social worker that he had made arrangements for a tonsillectomy on one of his children at a clinic which the worker had mentioned as a possible resource.

F. Summary

The physician requested a referral of the patient to the Mental Hygiene Clinic one week after admission to the hospital.

Before the social worker was able to contact the patient he voluntarily sought out Social Service help concerning the financial difficulties that had occurred at home due to his hospitalization. The social worker's role was to ease his mind by verifying for him that his family would be helped by a veterans' assistance agency.

The patient was to undergo a nasal operation. Accordingly, hospital discharge and referral for out-patient psychotherapy were delayed.

A relationship was developed between the patient and the social worker in the course of which he became too demanding. This was discussed in the weekly seminars with the psychiatrist and it was agreed that the social worker should be minimally active to lessen his dependency. The social worker suggested the financial and medical resources the patient could utilize for his family. The social worker sustained a rather supportive relationship with the patient who turned to her to discuss his financial difficulties and health problems in his home.

At the point of discharge the social worker discussed with the patient the referral to the Mental Hygiene Clinic. The patient accepted this treatment and after he was discharged he called the social worker, by pre-arrangement, to advise when

he would be able to keep his first appointment at the clinic, and incidentally to say that he was feeling much better as a result of the nasal operation.

The psychiatrist worked with the patient particularly in the area of marital difficulties, which were contributory to the patient's condition. The physician decided that the patient could function in the community while receiving outpatient treatment. He felt that the best therapy for this patient at the hospital was a somatic approach in surgically removing a nasal obstruction. The approach was effective in the light of the fact that the patient informed the social worker that after the operation he had felt better than he had in a long time.

D. Cases in Which the Role of the Social Worker was Primarily Related to Problems of Hospital Discharge, Community Placement, and Post-Hospital Treatment Plans.

Case VIII

Mr. Francis Stevens

A. Referral:

1. By Whom:

The first contact with the patient was occasioned by his appearing in the Social Service office requesting that his wife be interviewed for "a social investigation". The patient sought out the social worker the day after his admission to the hospital. Meanwhile, a referral was received from a staff neuropsychiatrist on this patient to contact the wife and initiate discharge plans with her.

Thus, although the physician made a formal referral, before this could be acted upon the patient appeared in the Social Service office. Technically,however, this case might be considered as a referral from the physician.

2. Reason for Referral:

The real reason for the self-referral was not immediately manifest, but it later developed that it had to do with the patient's effort to bring a punitive type of pressure to bear upon his wife and certain of her relatives from whose hands he had suffered, not only emotionally, but physically as well.

The physician felt that some adjustment might be

made with the patient and his family which would enable him to return home.

3. Point at Which the Social Worker Was Drawn in:

As has been stated, the social worker was activated almost immediately upon the patient's admission to the hospital.

4. Referral Conference:

a. Psychiatrist's Contribution and Information Obtained from the Records Available:

A brief account was given by the physician in the referral conference concerning the precipitating events leading to admission, including a self-inflicted superficial knife wound over the heart. This material was given to orient the social worker for work with the patient's relatives.

Because the worker was drawn in so early in the patient's hospital career, there was a negligible amount of material available in the clinical record.

b. Social Worker's Contribution:

At the point of initial referral the social worker had little to offer concerning an elaboration of social service role over and above what was suggested by the physician. At a later point in the referral process, the social worker did

contribute as to what different role might be played by the social worker.

B. Development of the Referral Process and the Developing Roles of the Psychiatrist and the Social Worker:

When the patient sought out the social worker he was essentially seeking the relationship for himself. He gave evidence of this when he poured out a great deal of material concerning his suicidal tendencies, his alcoholism, and his disturbed relationships with his wife and her protective brother, whom he physically feared.

Later, post-hospital treatment planning became focused upon a referral for out-patient psychotherapy. Building on the established relationship with the patient, the worker proceeded to arrange for such a plan. The past history of this patient included very poor results with psychotherapy in the community. It was therefore suspected that there would be in the patient a continuation of resistance against this type of treatment. This was confirmed by the experience which the psychiatrist was having with the patient during the current hospitalization and which in part convinced the physician that prolonged psychotherapy within the hospital would not be feasible. The physician then started to prepare the patient for treatment at the Mental Hygiene Clinic.

In the course of referral, the social worker was faced with the residual resistances in this patient which would

operate against a successful referral to out-patient psychotherapy. As stated, the worker utilized the already existing relationship with the patient to effect this referral. The social worker challenged the patient on whether he really wanted to go to the Mental Hygiene Clinic. "Did he really, sincerely believe that the psychotherapy as practiced in this Clinic would be helpful to him?" He had already gone to this Clinic on at least two occasions in the past and he had dropped treatment because he had felt it was not helping him. Throwing responsibility upon the patient for making a decision produced momentary anxiety, but he came through with what appeared to be a more genuine desire to go for treatment.

As for the original problem of dealing with the relatives, a reversal took place in this case, with the worker playing an important role in personal work with the patient and the psychiatrist seeing the relatives himself. It should be observed that the patient's presenting request to the social worker had been to interview his relatives for "a social investigation", but after a relationship had been established with the social worker, he brought his wife and mother in to see the psychiatrist when they visited the hospital.

C. Contribution of the Case Conference Discussions and Seminars to the Delineation of Roles:

In conferences with the physician subsequent to the first contact with the patient the value of the social worker's

relationship with him was set forth and the referral focus was consequently changed. Psychiatrically, the patient was found not to be schizophrenic, but it was believed that the anxiety state was of pre-schizophrenic proportions and that much of what superficially appeared to be evidence of psychopathy seemed a defense against the schizophrenic process. However, the patient had sufficient contact with reality to be able to react adequately to the social work interviews, and, as already described, certain things were worked out with him. The physician described the goals as limited,for this patient had a marked predisposition for his illness with many evidences of long standing character neurosis. He needed prolonged psychotherapy which this hospital did not provide, but which could be given at the Mental Hygiene Clinic since the patient was able to function in the community.

D. Relationship between the Nature of the Problem and the Roles of the Psychiatrist and the Social Worker:

This patient suffered from a severe anxiety state. At admission he was asocial and seclusive.

The marital relationship was characterized by frequent arguments and a reversal role, since the wife had become the wage earner and also the person in charge of the family.

The physician helped the patient to become less anxious and tense through individual interviews. He also helped the patient to overcome the resistance to utilize out-patient

psychotherapy for he considered that the patient needed prolonged treatment and could receive it while living at home.

The physician interviewed the patient's wife and mother in order to ease his return home.

The therapeutic relationship of the social worker with the patient, particularly as focused on the Mental Hygiene Clinic referral, had as its objective the preparation of the patient for treatment in the community. The social worker was active in reducing resistance of the patient to out-patient treatment. The social worker thus supplemented the role of the psychiatrist in preparing the patient for the follow-up treatment plan.

E. Effectiveness of the Social Worker:

Follow-up indicated that the patient's referral to the Mental Hygiene Clinic was effective. The patient derived benefit from regular psychiatric interviews, returned home to his wife, and in addition returned to a course of study in a local college which had been interrupted by his mental trouble.

F. Summary:

Originally the physician referred the patient for the relatives to be interviewed concerning the family background and to seek their cooperation for the patient's better adjustment at home. A reversal in the roles of the social worker and the doctor took place after a positive relationship was established with the patient upon a subsequent self-referral.

The physician then assumed the role originally assigned to the social worker, that of working with the family. Later, both the physician and the social worker worked in collaboration with the patient to help him accept out-patient psychotherapy after it was determined that he needed such prolonged treatment and could return to the community. The social worker was the one who actually effected the referral. His activity was effective, as verified by the follow-up of the case.

Case IX

Mr. Charles Richardson

A. Referral:

1. By Whom:

Chief of Neuropsychiatric Service.

2. Reason for Referral:

The social worker was to interview the patient concerning his social background with particular reference to the marital situation. His wife was said to have deserted him. The physician was interested in the marital status for purposes of eventual disposition.

3. Point at Which the Social Worker Was Drawn in:

The patient had a neurological problem which was suspected to stem from lues. He was referred to Social Service while the physician was deciding upon the kind of therapy he would administer to be based on the final diagnosis.

4. Referral Conference:

a. Psychiatrist's Contribution and Information Obtained from Records Available:

The initial orientation given by the physician was through the supervisor. The patient had been living continuously in hospitals in various states for several years. The pattern of seeking hospitalization in different parts of the country

was perhaps associated with the marital situation. The physician suggested a contact with the wife, if it was possible.

The physician also gave the patient's known diagnosis ("Left Sciatic Neuritis" and "History of Tertiary Syphilis").

The clinical record was read before the patient was interviewed. It consisted of the medical history and some social background.

b. Social Worker's Contribution:

There was a general discussion with the physician in the course of which it was decided that first the patient would be seen. From this the worker might be able to contact the missing wife.

B. Development of the Referral Process and the Developing Roles of the Psychiatrist and the Social Worker:

The role of the social worker was shifted after the initial contact with the patient when it was learned that his wife had deserted him four years ago and he had no idea where she was. The patient had no family ties whatsoever, which, in addition to actual need for treatment, contributed to his continuously seeking hospitalization.

The social worker's role became that of preparing the patient for eventual discharge to the community.

The treatment involved prolonged hospitalization. There

was also the problem of the patient's becoming too dependent on hospital life, which was apt to happen since he had very little positive in the community to attract him. Thus, the social worker tried to prevent the development of hospital fixation.

The social worker's activity in the actual plans of discharge was minimal. She limited her activity to helping the patient realize the need of his making some definite plans as to living arrangements. The patient initially resisted stating his plan to apply for admission at a veterans' domicile. He was told the procedure to follow in such application, though it was anticipated that he could not receive a domiciliary bed by the time of his discharge. The patient was gradually helped to accept discharge, which he resisted, and he proved to be efficient in making his own housing arrangements. All through the contacts with the patient the social worker had to meet the patient's hostility towards the hospital over the impending discharge at the same time that she avoided giving in to all his demands.

During the patient's hospitalization the physician's activity was mainly in treating his physical condition.

C. Contribution of the Case Conference Discussions and Seminars to the Delineation of Roles:

Subsequent discussions with the physician were in reference to how far the social worker could go in meeting this patient's requests. For instance, in his request for referral

to a veterans' institution in another part of the country the physician suggested that the social worker confine herself to telling him what procedures to follow in filling out an application. The main focus was to make hospital discharge appear to be desirable for the patient.

D. Relationship between the Nature of the Problem and the Roles of the Psychiatrist and the Social Worker:

The patient presented essentially a problem of chronic neurologic disease. There were disappointing experiences with women and strong pre-disposition to the development of institutional dependency, particularly during the more recent period of the patient's life.

The physician treated mainly the patient's neurological condition and while doing so he had to work also with the patient's strong dependency, for he kept suggesting treatments which would prolong hospitalization, including an operation.

The role of the social worker was in terms of a friendly interest in his future career with particular reference to his becoming independent of the hospital.

The second problem discussed was the handling of the patient's aggressive demands for services designed to prolong hospitalization as much as possible. Again the patient was encouraged to do things for himself within the limits of his capabilities.

E. Effectiveness of the Social Worker:

Effectiveness was in paving the way for the patient's

discharge and preventing hospital fixation. The patient was seen two weeks following discharge and the impression was that he had accepted his discharge. He would, however, still prefer a veterans' hospital admission, if such could be arranged.

F. Summary:

The physician referred the patient to Social Service early in the hospitalization to clarify the marital picture since this seemed to have some bearing on his constantly seeking hospitalization in different parts of the country.

The referral was made to the supervisor, the physician giving a resume of the patient's physical condition and the marital problem as known.

The role of the social worker was shifted after it was verified that the patient was permanently separated from his wife and her whereabouts were completely unknown to him. The social worker's role became that of preparing the patient for eventual discharge to the community. There was the need of working with the patient's growing dependency on hospital life. The social worker limited her activity to helping the patient realize the need of his making some definite plans in the community. He was gradually helped to accept discharge from the hospital and was able to make the necessary arrangements.

The social worker became a "target" for the patient's hostility toward the hospital when his discharge was definite.

The discussions with the physician were mainly on how far

the social worker could go in meeting the patient's requests.

The physician treated the patient's neurological condition and while doing so he had also to deal with the patient's strong dependency on hospital life.

Case X

Mr. Paul Carlson

A. Referral:

1. By Whom:

A staff physician, Neuropsychiatric Service.

2. Reason for Referral:

To interview the patient in order to obtain information concerning his social background relative to his illness.

3. Point at Which the Social Worker Was Drawn in:

The referral was made shortly after admission. The physician had not as yet established a diagnosis.

4. Referral Conference:

a. Psychiatrist's Contribution and Information Obtained from the Records Available:

The physician briefly gave the psychiatric picture insofar as it was known to him.

From the clinical record the social worker obtained a picture of the patient's symptoms, which supplemented the material given orally by the physician in the referral.

b. Social Worker's Contribution:

The social worker made no specific suggestions.

B. Development of the Referral Process and the Developing Roles of the Psychiatrist and the Social Worker:

The social worker had an interview with the patient in accordance with the referral. The information obtained was concerning the patient's relations with his family and occupational history.

Subsequently a referral was made by the physician on discharge plans. The physician indicated that the patient was feeling less anxious by being in the protected hospital environment, but the doctor had not accomplished much in terms of therapy. He suggested short contacts with the patient without rushing him.

The patient was found to be definite in his plan of continuing with his previous job. He tried to reduce the relationship with the female social worker to a boy-girl relationship. The social worker was not able to handle this problem effectively.

The behavior of the patient toward the social worker was discussed with the physician, who concluded that further contact of the patient with the social worker was pointless.

C. Contribution of the Case Conference Discussions and Seminars to the Delineation of Roles:

The primary contribution of the discussions of this case with the physician was in terms of the limited goals to be achieved in working with this patient. The physician had been

able to deal only with superficial material concerning the patient's past. The patient had remained rather uncommunicative in the areas dealing with his home, school adjustment, and his psychosexual adjustment. The physician utilized the social worker initially to secure a better picture of the patient's social background. The information obtained by the physician as well as the social worker generally showed that he had made a poor adjustment at home.

The physician indicated that there had been some improvement in the patient, but it was minimal. Since there was not much left that could be done to help the patient, the physician indicated that the social worker study the patient's plans for working after discharge. This was carried out with the results already described.

D. Relationship between the Nature of the Problem and the Roles of the Psychiatrist and the Social Worker:

At admission the patient was extremely nervous, tense,and anxious. He spoke in a very low voice, barely audible. There was no marked physical condition. The physician treated the patient in individual interviews, but the information obtained from the patient was very superficial. Whenever possible, he sought an excuse for obtaining a pass, admitting later that he did so in order to drink heavily. Nevertheless, the patient improved, becoming more sociable, and agreed to attend Occupational Therapy where he took part in some constructive

activities. He was discharged after receiving maximum hospital benefit.

The physician sought the help of Social Service in the area of gathering information concerning the patient's social background and plans for working after discharge.

E. Effectiveness of the Social Worker:

Effectiveness was limited to obtaining background diagnostic information.

F. Summary:

The physician referred the patient to Social Service to be interviewed concerning his social background with particular reference to its relation to his illness. The referral was early in his hospitalization. The social background and occupational history were superficially discussed.

A referral was made by the physician, this time for the purpose of discussing discharge plans. The patient stated that he was definitely going back to his previous job. Otherwise, nothing was accomplished in this interview, for the patient showed resistance in relating himself to the social worker in other than a boy-girl relationship.

The physician's treatment goal was limited. In the interviews the patient was very superficial in his productions, and drank heavily while out on passes.

The physician helped the patient to become less anxious and nervous through the stay in the protective environment of

the hospital. He referred the patient to Occupational Therapy, which proved to be beneficial.

The patient was discharged after minimal hospitalization when it was felt that he had received maximum hospital benefits.

CHAPTER IV

SUMMARY AND CONCLUSIONS

This is a study of ten cases in the neuropsychiatric ward at the Veterans Administration Hospital, West Roxbury, Massachuestts. These cases were studied for the purpose of determining: how the roles of the psychiatrist and the social worker are set up in given situations; how the roles are related to each other; the relationship between the problem and the way the roles are set up; and to shed light upon the nature of Psychiatric Social Work in particular reference to its relation to Psychiatry.

A brief description was given of what is meant by teamwork in a clinical setting, the collaboration between the psychiatrist and the social worker, and the factors influencing this teamwork.

A description of the hospital was given with particular reference to the Neuropsychiatric Service and the Social Service Department and the collaboration between the psychiatrist and the social worker.

The ten cases presented in the study were drawn from current or near current cases carried by members of the Social Service Department. Statistical sampling was not involved because of the small number of cases. The cases were selected

to illustrate the establishment of the social worker's role and its relationship with the psychiatrist's role. These cases were of short duration, extending from one week to two months.

This study was made under certain limitations: (1) there was a dearth of material for intensive study of the collaboration process; (2) the inherent nature of the subject is a difficult one; (3) because the setting was for acute-intensive treatment and the patient turnover was rapid, it was difficult to analyze in a leisurely manner what took place; (4) finally, there was no opportunity for complete follow-up of these cases to determine clearly how effective the treatment was.

The ten cases were presented according to a schedule. After the cases were studied, they were classified according to the main roles played by the social worker. The social work role was seen in reference to the problem presented by the patient. The general roles of the social worker appeared to be:

1. In direct treatment problems. (Cases I and II)
2. In dealing with relatives. (Cases III and IV)
3. In the area of economic hardships associated with the illness. (Cases V, VI, and VII)
4. In problems of hospital discharge, community placement, and post-hospital treatment plans. (Cases VIII, IX, and X)

Common elements found in these cases in regard to the way the roles of the social worker and the psychiatrist are set up

are discussed below.

A. Referral

1. Reason for Referral

The reasons for referral of these cases to Social Service were found to be varied. There were six reasons for referral as follows in order of their frequency:

(1) To ascertain the family's attitude toward the patient as a guide for treatment and discharge plans.

The physician recognizes that whatever his treatment plans may be, he cannot divorce them from the social milieu of the patient. On the contrary, these plans have to be based squarely on the environmental situation. From the beginning of treatment the physician has in mind ultimate discharge planning. The effectiveness of the doctor's treatment in terms of post-hospital adjustment may depend greatly on the family's attitude toward the patient. If negative, this can be modified in time to make possible an effective discharge.

The physician's role is mainly to treat the patient directly. There are situations, as in Case IV, where it is not therapeutically desirable for the physician to see the relative, for there may be danger in hurting the relationship already established with the patient.

(2) To help with environmental problems which were contributing to the patient's condition.

In this kind of referral we again see the physician's

awareness of the important role that environmental forces may have on the patient's condition. The physician understands the contribution that the social worker may make to the treatment process in this area.

(3) To gather information for diagnostic purposes through contact with the relatives.

(4) To give limited treatment to the patient's wife.

(5) To help plan for discharge.

It must be pointed out,though, that in all the ten cases the consideration of future discharge was continually kept in mind by the physician and the social worker.

(6) To work with relatives for the patient's benefit.

2. Point at Which the Social Worker Was Drawn in

The most significant point common to all the cases is that the social worker was drawn in early in the patient's hospitalization to help in establishing a diagnosis, in planning treatment and ultimate discharge. This would imply that whatever activity is carried out by the social worker should be prompt and at the tempo of the physician's activity.

Another significant point is that the physician sought the help of the social worker when he considered it necessary. This is an indication that in every instance the physician is the leader of the clinical team, seeking the service of the social worker for those patients he considers would benefit from this service.

B. Development of the Referral Process and the Developing Roles of the Psychiatrist and the Social Worker

In the study of the development of these cases we find certain common factors, namely:

1. That whatever the reason for referral, new areas of functioning invariably open for the psychiatrist and the social worker in the course of the contact with the patient or his relatives.

2. There is no rigid pattern regarding the role of the psychiatrist and the social worker. Although the general areas of both are delineated, with the physician generally dealing with the patient and the social worker with relatives, there may be a reversal of roles according to the nature of the particular case.

3. No matter what role the social worker and the psychiatrist play in a given case, their common objective is to help the patient achieve a better adjustment and be able to return to the community as soon as it is at all possible.

4. Whatever their roles may be, both the physician and the social worker keep in mind the limitations in their goals as based on the nature of the patient's problem and the setting.

C. Mechanisms of Collaboration and their Contribution to the Delineation of Roles

An important factor that contributed to the psychiatrist

and the social worker utilizing their maximum capabilities in helping these patients was their collaboration. The common characteristics that we find in the cases studied concerning this collaboration are as follows:

1. The physician is the leader of the psychiatric team.

2. Collaboration between the two initiated at the original referral when the physician gave some orientation to the social worker as to the nature of the patient's problem and offered some suggestions to the social worker as to the Social Service activity. The social worker in turn made his contribution giving suggestions, and both determined what plan to follow.

3. Further activities carried out by the physician and the social worker were discussed in conferences and treatment plans were made accordingly.

Although the physician guided the social worker, simultaneously another process occurred, the dependency of the physician on the social worker for guidance based on the social worker's findings, so that he could discharge his role intelligently. This constitutes a definition of collaboration. The physician does not teach exclusively, for his relationship with the social worker is also a learning process for himself.

This collaboration helped also in understanding the limitations of the goals and in clarifying each other's roles.

4. The working out of these cases was not done in a

routine manner. Their success depended on the close relationship between the physician and the social worker and other members of the hospital staff concerned. Although the physician was the leader, there was close cooperation, mutual respect and confidence, which are indispensable factors to carry on successful teamwork.

Approved,

Richard K. Conant

Richard K. Conant
Dean

APPENDIX A

SCHEDULE

A. Referral

1. By whom?
2. Reason for referral.
3. Point at which the social worker was drawn in.
4. Referral conference.
   a. Psychiatrist's contribution and information obtained from the records available.
   b. Social worker's contribution.

B. Development of the referral process and the developing roles of the social worker and the psychiatrist.

1. Activity carried out by the social worker according to the original referral.
2. Reason motivating a new evaluation of the referral, if this occurred.
3. Activity of the social worker according to the new referral.
4. Description of the roles of the social worker and the psychiatrist according to the development of the case.

C. Contribution of case conference discussions and seminars to the delineation of roles.

1. Description of the conferences which helped to clarify the roles of the psychiatrist and the social worker as the case developed.

D. Relationship between the nature of the problem and the roles of the psychiatrist and the social worker.

1. Description of the nature of the problem as it affected the roles to be played by the psychiatrist and the social worker.

a. The role of the psychiatrist.

b. The role of the social worker.

E. Effectiveness of the social worker.

1. Evident effectiveness either positive or negative according to the results.

APPENDIX B

DESCRIPTIVE MATERIAL ON ORGANIZATION OF THE VETERANS ADMINISTRATION

"The Veterans Administration as it is operating today is a result of the consolidation on July 21, 1930, of three federal agencies serving veterans: U. S. Veterans Bureaus, Bureau of Pensions and the National Home for Disabled Volunteer Soldiers. The Veterans Administration is an independent establishment of the executive branch of the federal government authorized by Act of Congress and created by Executive Order. The major responsibility of the Veterans Administration is to administer specific laws enacted by the Congress for the benefit of former members of the military and naval forces." (Jack M. Stipe, "Social Service in the Veterans Administration", Journal of Social Casework. Vol. XXIX, No. 2 (February, 1948), p. 43.

The medical services in Veterans Administration hospitals are authorized and established by Public Law 293 79th Congress, under which the Department of Medicine and Surgery is set up. Under the so-called Deans Committee Plan Class A medical schools cooperate with Veterans Administration hospitals "to create and maintain the highest possible professional standards of medical care for veterans...Committees have been chosen by the deans of medical schools to supervise the medical care and training programs in Veterans Administration hospitals...The Deans Committee chooses a number of senior consultants from among the outstanding medical authorities of the area...Also a larger number of attending specialists whose responsibility it is to supervise and direct more closely the graduate training of Veterans Administration physicians and the care of patients." (Quoted from Veterans Administration, Public Relations Service,"The Deans Committee Plan", Fact Sheet No. 22850, 1947. Mimeographed)

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